# STATE OF CONNECTICUT
## DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

June 26, 2019

Mr. Peter Adamo, Administrator
Waterbury Hospital
64 Robbins St
Waterbury, CT 06721

Dear Mr. Adamo:

An unannounced visit was made to Waterbury Hospital on June 13, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a revisit to a federal deficiency statement dated May 10, 2019.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

**The plan of correction is to be submitted to the Department by July 6, 2019.**

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by **July 4, 2019** or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.
An office conference has been scheduled for **July 2, 2019** at **1:00 PM** in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.

Phone: (860) 509-7400 • Fax: (860) 509-7543
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DATE OF VISIT: June 13, 2019

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SN/PB:jf:

DATE OF VISIT: June 13, 2019

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2)(B) and/or (i) General (6).

1. *Based on a review of clinical records, interviews, and policy review, for three (3) of six (6) patients' reviewed for observation status (Patient #1, #6, and #7), the hospital failed to ensure the clinical record reflected a patient assessment by the physician when the level of observation was changed. The findings include the following:
    a. Patient #1 was brought to the ED on 6/11/19 with Suicidal Ideation with a plan. Review of the triage assessment indicated that the patient was identified as a high risk for suicide based on the suicide risk assessment and was placed on one to one observation. Review of the physician's orders dated 6/11/19 at 4:00 AM directed continuous observation. Review of the record failed to reflect a reassessment of the patient by the clinician to support the change in observation level. Interview with MD #1 on 6/13/19 at 10:19 AM indicated that on admission the patient was inebriated and after a few hours was clearer and was no longer verbalizing suicidal statements. Review of the record failed to reflect a documented assessment of the patient.
    b. Patient #6 presented to the ED on 6/8/19 at 8:06 PM after trying to asphyxiate self. Review of the record with the Quality Manager on 6/13/19 at 11:00 AM indicated that the suicide risk assessment identified that the patient denied attempting suicide and was low risk. The patient was placed on one to one observation. The record reflected that the physician's order dated 6/10/19 at 8:45 PM directed continuous observation. Although there was a physician's order for the observation change, the record failed to reflect a reassessment of the patient by the clinician to support the change in observation level.
    c. Patient #7 presented to the ED on 6/9/19 at 8:11 PM with suicidal and homicidal ideation. Review of the record with the Quality Manager on 6/13/19 at 11:10 AM indicated that the suicide risk assessment identified that the patient was a high risk and was placed on one to one observation on 6/9/19 at 8:20 PM and was discontinued on 6/10/19 at 8:09 AM. A physician's order dated 6/10/19 at 8:19 AM directed continuous observation. Review of the record failed to reflect a reassessment of the patient by the clinician to support the change in observation level.

    Review of the Risk Assessment and Management of Patients Requiring Observation indicated that a reevaluation of observation by a provider will occur on an ongoing basis.